

1. PLACE OF DEATH o. COUNTY <u>SOMERSET</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARION STA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARION STA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>McCREADY HOSPITAL CRISFIELD</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>HENRY</u> Middle <u>BORDEN</u> Last <u>SR.</u>				4. DATE OF DEATH <u>MARCH</u> Month <u>9</u> Day <u>1957</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 5, 1940</u>	
				9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School boy -</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>MARION STA, MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>GEORGE SAMUEL BORDEN</u>				14. MOTHER'S MAIDEN NAME <u>TAUKITA YOUNG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Emboli</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Appendectomy Mar. 4 - 1957 -</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 28, 1957</u> , to <u>Mar. 9, 1957</u> , that I last saw the deceased alive on <u>Mar. 9, 1957</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Marion Sta. Md.</u> DATE SIGNED <u>3-11-57</u> ACTUAL SIGNATURE <u>George C. Coulbourn M.D.</u> PHYSICIAN'S NAME (Type) <u>GEORGE C. COULBOURN MD</u> <u>Marion Sta. Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Mar. 12 - 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Marion Sta. Som. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George H. Telghman</u> ADDRESS <u>Marion Sta. Md.</u>				24. REC'D BY REGISTRAR <u>3-11-57</u>		24b. REGISTRAR'S SIGNATURE <u>Nellie D. Payne</u>	

BUREAU V. S.

MAR 15 1957

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03329

CERTIFICATE OF DEATH

03328

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>Somerset</u> MARYLAND CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dames Quarter</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>at home</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Somerset</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dames Quarter</u> STREET ADDRESS (If rural give location) <u>Just off Main Road</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John Vaughn Bozman</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3/27</u> 19 <u>57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>5/14/1869</u>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>oystering</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>John R. Bozman</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS <u>Mrs. William J. McInturff</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <u>Congestive Failure</u>		1 week	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>		years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Malnutrition</u>		months	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Malnutrition</u>		months	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>8:45PM</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21f. HOW DID INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>3-23-57</u> , 19 <u>57</u> , to <u>3-27-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3-27-57</u> , 19 <u>57</u> , and that death occurred at <u>8:45PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Everett C. Sutter</u> M.D.		ADDRESS (Street, city, town, state) <u>Dames Quarter, Maryland</u> DATE SIGNED <u>3-30-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>	DATE THEREOF <u>3/31/57</u>	NAME OF CEMETERY OR CREMATORY <u>private Bozman cemetery</u>	LOCATION (City, town, or county) (State) <u>Dames Quarter Md.</u>
24. REC'D BY REGISTRAR <u>4/1/57</u>	REGISTRAR'S SIGNATURE <u>Lola J. Wheatley</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>L. G. Webster</u>	ADDRESS <u>Acad Island Md.</u>

CERTIFICATE OF DEATH

Form No. 100

1. FULL NAME (PRINT OR TYPE)

2. SEX

3. RACE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF CHURCH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

03330

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03330

Reg. Dist. No.

260

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover, Md</u>		c. LENGTH OF STAY IN 1b <u>2 1/2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover Maryland</u> x			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>Aldon</u> Last <u>Collins</u>				4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 26-1957</u>	
9. AGE (In years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u>6</u> Min. <u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bob</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leonard Aldon Horsey</u>				14. MOTHER'S MAIDEN NAME <u>Hauett Collins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>5000182 XV 2</u>		17. INFORMANT <u>Hauett Collins</u> Address <u>Westover Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>From history probably</u> <u>763.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Burch pneumonia</u> (a), stating the underlying cause last. DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.H. Johnson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.H. Johnson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 5-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James Methodist Church - Westover Maryland</u>		22d. LOCATION (City, town or county) (State) <u>Westover Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carl Amurod - Westover, Maryland</u> (Cousin to Mother)				24a. REC'D BY REGISTRAR <u>3/7/57</u>		24b. REGISTRAR'S SIGNATURE <u>R.H. Johnson, M.D.</u>	

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

03323

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03331

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 Crisfield			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 334 Broadway				d. STREET ADDRESS 1 334 Broadway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM - DIZE				4. DATE OF DEATH Month Day Year March 19, 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 12, 1874	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Dize				14. MOTHER'S MAIDEN NAME Maggie Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Legolia R. Dize, Crisfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO (b) Coronary Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dr. William H. Coulbourn				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. William H. Coulbourn				DATE SIGNED 3/27/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/57		22c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Harvey Bradshaw				ADDRESS Crisfield, Md.		24a. REC'D BY REGISTRAR DATE 3/25/57	
						24b. REGISTRAR'S SIGNATURE Barbara S. [Signature]	

WEST VIRGINIA STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		35		March 28, 1957	
Place of Birth		Occupation		Cause of Death		Manner of Death	
Baltimore, Md.		Teacher		Heart Disease		Natural	
Residence		Hospital		Physician		Pathologist	
123 Main St.		St. Mary's		Dr. Smith		Dr. Jones	
Time of Death		Place of Death		Signature of Examiner		Signature of Physician	
10:00 AM		St. Mary's		[Signature]		[Signature]	
Remarks		Disposition of Body		Burial Place		Burial Date	
None		Buried		St. Mary's		March 29, 1957	

BUREAU V. 2

MAR 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

03330

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03332

Reg. Dist. No. 360

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u>		c. LENGTH OF STAY IN 1b <u>6 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover X /</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u></u> Last <u>Dunn</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>19 57</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 15. 1879</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas Dunn</u>				14. MOTHER'S MAIDEN NAME <u>Coday</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Mr. Russell Dunn Westover, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension and Chronic Myocarditis</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs -</u> <u>years -</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. H. Johnson</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. H. Johnson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3-18-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Andrews Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Princess Anne, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis Wilson</u>				ADDRESS <u>Princess Anne, Md.</u>		24a. REC'D BY REGISTRAR <u>3/18/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>R. H. Johnson, M.D.</u>			

PP

DATE SIGNED
March 18. 1957

97

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, date, time, place, and cause of death. The form is mostly blank with some faint, illegible markings.

RECEIVED
MAR 20 1957
BUREAU V. 1

03331
CERTIFICATE OF DEATH

Reg. Dist. No. 965

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. # 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CELIA Middle ANN Last HAN DY		4. DATE OF DEATH Month March Day 11 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Horsey		14. MOTHER'S MAIDEN NAME Mary Lawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT John W. Handy--R.F.D. # 1--Crisfield, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Cerebral Vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Hypertension in 1953		INTERVAL BETWEEN ONSET AND DEATH few min 2 days Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension in 1953		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/17 , 19 53 , to 3/11 , 19 57 , that I last saw the deceased alive on 3/10 , 19 57 , and that death occurred at 5 9 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE P. N. Barr, M.D. M.D.		ADDRESS (Street, city or town, state) Crisfield, Md. DATE SIGNED 3/12/57	
PHYSICIAN'S NAME (Type) Dr. A. N. Barr		Main St.--Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 13, 1957	22c. NAME OF CEMETERY OR CREMATORY Private Family Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield R.F.D., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		24a. REC'D BY REGISTRAR 3/26/57 24b. REGISTRAR'S SIGNATURE Barton S. Adams	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be checked for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03332

CERTIFICATE OF DEATH

03334

Reg. Dist. No. 365

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marion	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hudson's Corner		d. STREET ADDRESS Hudson's Corner	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES W. JOHNSON		4. DATE OF DEATH Month Day Year March 20, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 8, 1885
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John S. Johnson		14. MOTHER'S MAIDEN NAME Rose Dixon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Mrs. Virginia Johnson, Marion, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Tonic myo carditis c. acute dilatation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial pneumonia (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 8 hrs. 7-8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic interstitial nephritis, Hepatomegaly.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1945, to March 20, 1957, that I last saw the deceased alive on March 20, 1957, and that death occurred at 8 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. G. Rawley		ADDRESS (Street, city or town, state) Crisfield, Md.	
PHYSICIAN'S NAME (Type) Dr. C. G. Rawley		DATE SIGNED 3/22/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/57	
22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) (State) Marion, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Harvey Bradshaw		ADDRESS Crisfield, Md.	
24a. REC'D BY REGISTRAR DATE 3/22/57		24b. REGISTRAR'S SIGNATURE Barton S. Adams	

14

1. *Corvus*

... ..

MAR 26 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
03333 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03335

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield c. LENGTH OF STAY IN 1b 39 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Somerset c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Delia Middle Anne Last Ward Jones		4. DATE OF DEATH Month 3 Day 10 Year 1957	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 31, 1927
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months 2 Days 9	IF UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sea food		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Crisfield		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Ward		14. MOTHER'S MAIDEN NAME Genera Norfleet	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 174-22-154	
17. INFORMANT Mabel Douglas - Crisfield, Md.		Address Crisfield, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Six Bullets Shot in Head & Body DUE TO (b) 7 NECK - Shock & Hemorrhage Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. William H. Coulbourn, M.D. DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO DEATH DEPUTY MEDICAL EXAMINER FOR SOMERSET COUNTY, MD.			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Arguing with Lincoln Mills the brother	
20c. TIME OF INJURY Month, Day, Year 6:15 p.m. March 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Her Home		20f. City or town Crisfield (County) Somerset (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Wm H Coulbourn		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Crisfield Ind		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/57	
22c. NAME OF CEMETERY OR CREMATORY Shiloh-Lawson		22d. LOCATION (City, town, or county) Crisfield, Som. Co. Md. (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Ward - Marion St., Md.		24a. REG'D BY REGISTRAR 3/14/57	
		24b. REGISTRAR'S SIGNATURE Burtan S. Adams	

DATE SIGNED

March 12/1957

RECEIVED

MAR 15 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03336

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH o. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesle</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Chesle</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Thomas</u> Last <u>Laird</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>15</u> Year <u>1937</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Asbury Laird</u>		14. MOTHER'S MAIDEN NAME <u>Kesiah Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Hoyt Somers Chesle md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> <u>448X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 15 1955</u> to <u>March 15 1957</u> , that I last saw the deceased alive on <u>March 15 1957</u> , and that death occurred at <u>9:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eldon G. Marksman</u> M.D.		ADDRESS (Street, city or town, state) <u>Princess Anne md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Eldon G. Marksman</u>		<u>Princess Anne md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Order of Mechanics</u>	22d. LOCATION (City, town, or county) (State) <u>Chesle md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Sumner</u>		24a. REC'D BY REGISTRAR <u>R. H. Johnson, M.D. gr</u> DATE <u>3/18/57</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER			
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		HOMICIDE		OTHER					
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER							
IMMEDIATE CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER							
INTERMEDIATE CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER							
FUNDAMENTAL CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER							
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH					
DATE OF REPORT		TIME OF REPORT		PLACE OF REPORT		CITY OF REPORT		STATE OF REPORT		COUNTRY OF REPORT					
REPORTED BY		NAME		ADDRESS		CITY		STATE		COUNTRY					
SIGNATURE OF REPORTER		NAME		ADDRESS		CITY		STATE		COUNTRY					
DATE OF SIGNATURE		TIME OF SIGNATURE		PLACE OF SIGNATURE		CITY OF SIGNATURE		STATE OF SIGNATURE		COUNTRY OF SIGNATURE					

BUREAU V. 31

MR 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03324

CERTIFICATE OF DEATH

03337

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cresfield</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cresfield</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Walnut Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John William Landon Sr.</u>				4. DATE OF DEATH <u>Nov 20 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 20 1878</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Relieved Workman</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Thomas Landon</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Conrad</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mr. Samuel Revelle</u> Address <u>Dopewell Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Hypertension</u> <u>4 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY a. H. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> , 19 <u>45</u> , to <u>Nov 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 20</u> , 19 <u>57</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sarah M. Peyton</u>				ADDRESS (Street, city or town, state) <u>Cresfield, Md</u>		DATE SIGNED <u>3/25/57</u>	
PHYSICIAN'S NAME (Type) <u>Sarah M. Peyton</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/23/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Somerset</u>		22d. LOCATION (City, town, or county) (State) <u>Dopewell Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Thomas</u> ADDRESS <u>Cresfield Md</u>				24a. REC'D BY REGISTRAR <u>3/26/57</u>		24b. REGISTRAR'S SIGNATURE <u>Barbara L. Adams</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04466

4460

CERTIFICATE OF DEATH

Reg. Dist. No.

265

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cresfield</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>396 Cresfield</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hudson St.</u>				d. STREET ADDRESS <u>1 Hudson</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>E.</u> Last <u>Landon</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 20, 1882</u>		9. AGE (In years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward J. Justice</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Landon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Herman Landon</u> Address <u>Cresfield md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure & Pulmonary edema</u> <u>447X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 26</u> , 19 <u>57</u> , to <u>Mar 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 28</u> , 19 <u>57</u> , and that death occurred at <u>3:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sarah M. Peyton</u> M.D.				ADDRESS (Street, city or town, state) <u>334 W. Main St Cresfield</u>		DATE SIGNED <u>4/3/57</u>	
PHYSICIAN'S NAME (Type) <u>Sarah M. Peyton</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunny Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Hopewell md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hannon</u> ADDRESS <u>Cresfield md</u>				24a. REC'D BY REGISTRAR DATE <u>4/6/57</u>		24b. REGISTRAR'S SIGNATURE <u>Barbara L. Adams</u>	

BUREAU V. S.

APR 10 1957

RECEIVED

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cresfield</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cresfield</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>McCreedy Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>E.</u> Middle <u>L.</u> Last <u>Lawson</u>				4. DATE OF DEATH <u>Mar.</u> Month <u>17</u> Day <u>1957</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 26</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Robert Lee Lawson</u>			
14. MOTHER'S MAIDEN NAME <u>Ellen Byrd</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>md.</u>				17. INFORMANT <u>Harold S. Lawson</u> Address <u>Cresfield</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Toxic Myocarditis</u> DUE TO (c) <u>Pneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>11 days</u> <u>12 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis Heart Disease. Cerebral Vascular Accident</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 6</u> , 19 <u>55</u> , to <u>March 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>March 17</u> , 19 <u>57</u> , and that death occurred at <u>9:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. N. Barr, M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>Cresfield, Md.</u>			
DATE SIGNED <u>3/19/57</u>				PHYSICIAN'S NAME (Type) <u>A. N. BARR, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunnyside</u>		22d. LOCATION (City, town, or county) (State) <u>Dopenwell Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Turner</u> ADDRESS <u>Cresfield Md.</u>				24a. REC'D BY REGISTRAR <u>Barlow S. Adams</u>		24b. REGISTRAR'S SIGNATURE <u>Barlow S. Adams</u>	

BUREAU V. S.

MAR 26 1957

RECEIVED

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03336

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH o. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
c. LENGTH OF STAY IN 1b Lifetime		d. STREET ADDRESS R.F.D. Hopewell Section	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. Hopewell Section		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDITH Middle LILLIAN Last LONG		4. DATE OF DEATH Month March Day 5 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1869
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Dr. George Berry		14. MOTHER'S MAIDEN NAME Mary E. Coulbourn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Jesse L. Long--Crisfield, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (Coronary - cerebral) DUE TO (c) 10 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Alzheimers (senile) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 5, 1957 to March 5, 1957 that I last saw the deceased alive on March 5, 1957 , and that death occurred at 10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Sarah M. Peyton		DATE SIGNED 3/6/57	
PHYSICIAN'S NAME (Type) Dr. Sarah M. Peyton		Main St. Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 8, 1957	
22c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		24a. REC'D BY REGISTRAR 3/7/57	
24b. REGISTRAR'S SIGNATURE Bastara S. Adams			

ATLANTIC STATE DEPARTMENT OF HEALTH - BUREAU OF DEATH
CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
June 15, 1957		New York City		Heart Disease	
Time of Death		Physician		Manner of Death	
10:30 AM		Dr. J. Smith		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Entry		Place of Entry		Cause of Entry	
June 16, 1957		New York City		Heart Disease	
Time of Entry		Physician		Manner of Entry	
11:00 AM		Dr. J. Smith		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

BUREAU V. 2

MAR 8 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McCready Hospital				d. STREET ADDRESS 1 Smith Island			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JOHN STRAUGHAN MARSHALL				4. DATE OF DEATH March 10 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 12, 1909	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman				10b. KIND OF BUSINESS OR INDUSTRY Seafood Catching		11. BIRTHPLACE (State or foreign country) Tylerton, Md.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Howard Marshall				14. MOTHER'S MAIDEN NAME Venie Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Edison Marshall--Tylerton, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO 163X Cardiac Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Left Lung DUE TO (c) 9 mo PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/19 , 19 56 , to 3/10 , 19 57 , that I last saw the deceased alive on 3/10 , 19 57 , and that death occurred at 5 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crisfield, Md. DATE SIGNED 3/10/57							
ACTUAL SIGNATURE A. N. Barr, M.D. M.D. Crisfield, Md.							
PHYSICIAN'S NAME (Type) Dr. A. N. Barr				Main St.--Crisfield, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 13, 1957		22c. NAME OF CEMETERY OR CREMATORY Tylerton Cemetery		22d. LOCATION (City, town, or county) (State) Tylerton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md. ADDRESS				24a. REC'D BY REGISTRAR 3/26/57 DATE		24b. REGISTRAR'S SIGNATURE Barton S. Adams	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03341

03325

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cristfield</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Abraham Link Mills</u>		4. DATE OF DEATH Month <u>3</u> Day <u>10</u> Year <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9, 1907</u> 49 yrs.
9. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Band Player</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Hopewell, Somco.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.A.S.</u>		13. FATHER'S NAME <u>James Mills</u>	
14. MOTHER'S MAIDEN NAME <u>Jennie Jones</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Pearl Ball</u> Address <u>Hopewell, Som. Co., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot, wound Left side face</u> DUE TO (b) <u>Left Eye & Chin & Skull shot</u> DUE TO (c) <u>off-shock Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>He shot himself</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>He shot himself</u>	
20c. TIME OF INJURY Month, Day, Year <u>Nov 10 1957</u> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> (City or town) <u>Cristfield</u> (County) <u>Somerset</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Wm H Coulbourn</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/57</u>	
22c. NAME OF CEMETERY <u>Hopewell</u>		22d. LOCATION (City, town, or county) (State) <u>Hopewell, Som. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u> ADDRESS <u>Marion Sta., Md.</u>		24a. REC'D BY REGISTRAR <u>3/14/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Barton S. Adams</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03342

03326

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b Life			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 39 Crisfield							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Byrdtown Rd.				d. STREET ADDRESS 1 Byrdtown Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First J. Middle ELLIS Last TAWES				4. DATE OF DEATH Month Mar ch Day 21 , Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1899		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant & Legislator		10b. KIND OF BUSINESS OR INDUSTRY Confectionery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Tawes				14. MOTHER'S MAIDEN NAME Lillian Ward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1		17. INFORMANT Address Norris Tawes, Crisfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetic Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hangover, left by (post-op state) and right middle toe							INTERVAL BETWEEN ONSET AND DEATH few minutes Known 8 months
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/12 , 19 56 , to 3/21 , 19 57 , that I last saw the deceased alive on 3/20 , 19 57 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE A. N. Barr				ADDRESS (Street, city or town, state) Crisfield, Md.		DATE SIGNED 3/23/57	
PHYSICIAN'S NAME (Type) Dr. A. N. Barr							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/24/57		22c. NAME OF CEMETERY OR CREMATORY American Legion Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Harry Bradshaw				ADDRESS Crisfield, Md.		24a. REC'D BY REGISTRAR DATE 3/29/57	
						24b. REGISTRAR'S SIGNATURE Bartow J. Adams	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES		MALE		35		JAN 15 1922	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS	
LABORER		HEART DISEASE		NATURAL		2 WEEKS	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
APR 1 1957		BALTIMORE		BALTIMORE		MARYLAND	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION	
J. H. [Signature]		[Signature]		APR 1 1957		BALTIMORE	

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APR 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03343

03338

CERTIFICATE OF DEATH

Reg. Dist. No.

360

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRMOUNT</u>		c. LENGTH OF STAY IN 1b <u>80</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LEWIS</u> First <u>J</u> Middle <u>WASHINGTON</u> Last		4. DATE OF DEATH <u>MAR</u> Month <u>1</u> Day <u>1957</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 21-1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec. Foodwork</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>FAIRMOUNT, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN, H. WASHINGTON</u>		14. MOTHER'S MAIDEN NAME <u>LUCRETIA, HALL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Washington, FAIRMOUNT, MD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 24, 1957</u> to <u>March 1, 1957</u> that I last saw the deceased alive on <u>Feb 25, 1957</u> , and that death occurred at <u>11:07 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eldon G. Marksmann</u> M.D.		ADDRESS (Street, city or town, state) <u>Princess Anne, MD</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Eldon G. Marksmann</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR 21 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CENTENIAL</u>		22d. LOCATION (City, town, or county) (State) <u>FAIRMOUNT, SOM, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHARLES, H. WARD</u> ADDRESS <u>MARION, MD</u>		24a. REC'D BY REGISTRAR <u>3/6/57</u> 24b. REGISTRAR'S SIGNATURE <u>R. Johnson, M.D.</u>	

CERTIFICATE OF DEATH

THE STATE OF

MARYLAND

COUNTY OF BALTIMORE

DECEASED

TO

DATE

WILLIAM J. HARRIS
MAY 1 1957
BALTIMORE, MARYLAND
FATHER OF THE DECEASED
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BUREAU V. S.

MAR 8 1957

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